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| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

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| F0000 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: July 11, 12, 13, 14, 15, 2011<br><br>Facility number: 000115<br>Provider number: 155208<br>AIM number: 100291080<br><br>Survey Team:<br>Donna Groan RN, TC<br>Avona Connell RN [July 11, 12, 13, 14, 2011]<br>Dorothy Navetta RN<br>Gloria Reisert MSW<br><br>Census bed type:<br>SNF/NF 69<br>Residential: 08<br>Total: 77<br><br>Census payor type:<br>Medicare: 6<br>Medicaid: 56<br>Other: 15<br>Total: 77<br><br>Sample: 15<br>Supplemental sample: 14<br>Residential sample: 07 | F0000 | **Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the state of deficiencies. This Plan of Correction is prepared and submitted because of requires of State or Federal law. Please accept this plan of correction as our credible allegation of compliance.** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | These deficiencies also reflect state findings in accordance with 410 IAC 16.2.<br><br>Quality review 7/22/11 by Suzanne Williams, RN | | | |
| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>A. Based on record review and interview, the facility failed to notify the physician and responsible party when a resident had experienced an episode of choking while | F0157 | **The facility will ensure this requirement is met through the following corrective measures.**<br>**1. Resident number #52's family and physician were** | 08/14/2011 |

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| | eating. This deficient practice affected 1 of 1 resident who experienced a choking episode while eating in a sample of 15 residents. (Resident #52)<br><br>B. Based on record review, interview and observation, the facility failed to notify the physician or family an assessment had not been completed as ordered for physical therapy (P.T.), occupational therapy (O.T.) and speech therapy (S.T.) for 1 of 3 residents reviewed for therapy in a sample of 15. (Resident # 22)<br><br>C. Based on record review, observation and interview, the facility failed to ensure a the physician was notified of an order for footwear which was not obtained for 1 of 1 resident reviewed for footwear in a resident sample of 15 and failed to notify the physician/family medication was not provided as ordered for 1 of 15 residents reviewed for medication administration in the sample of 15. (Resident #1, #91)<br><br>Findings include:<br><br>A.1. Review of the clinical record for Resident #52 on 7/13/2011 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to, multi-infarct dementia, cataracts, and status post cerebral vascular accident (stroke). | | **notified of the episode of the resident getting choked up. Resident number #22's family and physician have been notified that the PT, OT, and ST assessment had not been completed timely. Resident #1's family and physician were notified that the order for footwear was not addressed timely. Resident #91 deceased. 2. All residents have the potential to be affected. Nurse' s Notes reviewed for past 30 days to ensure physician/family notification made when indicated. 3. a. The physician/family notification with acute changes in condition policy and procedure was reviewed and no changes were indicated at this time (see attachment A). Licensed staff were re-educated on the procedure. The DON or her designee will review Nurse's Notes daily on scheduled work days to ensure physicians and family members are notified timely with changes in condition indefinitely. (See attachment B). b. The medication administration policy was reviewed and no changes were indicated (see attachment I). Licensed staff were re-educated on that policy. The DON or her designee will audit MAR's three** | |

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| | Review of the nursing notes between 3/1/2011 and 7/13/2011, the following entry was noted:<br>- "5/5/11 - 11 p [p.m.]: when feeding res [resident] supper this evening, res. noted to get choked up on liquids & food. Res noted to lean head back & when repositioned repeated this..."<br>Documentation was lacking of the physician and the responsible party having been notified of the episode.<br><br>During an interview with the Director of Nursing [DoN] on 7/13/2011 at 2:00 p.m., she indicated that the resident has a tendency to cough and some staff will chart it as choking. She further indicated the physician and responsible party had not been notified of the incident.<br><br>On 7/14/2011 at 1:35 p.m., the Administrator presented a copy of the facility's current policy on "Physician & Family Notification Procedure". Review of the policy at this time included, but was not limited to: "Purpose: To keep the physician, resident, and family appraised of all condition changes. Procedure: Telephone:...2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan..."<br>B. On 7/13/2011 at 9:05 a.m. record review indicates Resident # 22 has | | **times weekly for four weeks, then twice weekly for four weeks, then weekly for four weeks then monthly thereafter to ensure medications are administered as ordered (see attachment Z).** c. The policies related to Physician Orders and therapy screens were reviewed and no changes were indicated at this time (see attachments J and Sa). The DON or her designee will review all new physician orders daily on scheduled work days indefinitely to ensure follow through (see attachment B). The Administrator or her designee will review all therapy screen requests daily on scheduled work days indefinitely to ensure screens are completed timely (see attachment Sb). **4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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| | diagnoses of, but is not limited to; dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia.<br><br>Review of physician orders dated 6/27/2011 indicated P.T., O.T. and S.T. were to assess Resident # 22. Documentation was lacking that P.T., O.T., and S.T. had assessed the resident.<br><br>On 7/13/2011 at 11:15 a.m. Licensed Practical Nurse (L.P.N.) # 3 indicated that O.T., P.T., and S.T. had not yet assessed resident.<br><br>On 7/13/2011 at 11:15 a.m. Medical Doctor (M.D.) # 1 was observed to be on the unit that Resident # 22 resides.<br><br>On 7/14/2011 at 9:30 a.m. review of nursing notes lacked documentation that the physician or family had been notified that O.T., P.T., and S.T. had not assessed Resident # 22.<br><br>On 7/14/2011 at 10:15 a.m. review of the physician progress notes lacked documentation that he had been notified the assessment had not been done.<br><br>On 7/14/2011 1:35 p.m. review of the facility's PHYSICIAN & FAMILY NOTIFICATION PROCEDURE indicated | | | |

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| | "PURPOSE: To keep the physician, resident and family appraised of all condition changes. PROCEDURE: Telephone: 2. Notify the physician of any change in condition that may or may not warrant a change in the treatment plan."<br><br>C. 1. During the initial tour on 7/11/11 between 9:15 a.m. and 10 a.m., resident #1 was observed propelling in a wheelchair. At the time, the resident had ankle length socks to both feet.<br><br>The clinical record for Resident #1 was reviewed on 7/11/11 at 1 p.m. The resident's diagnoses included, but were not limited to venous stasis ulcers and morbid obesity. A physician progress note dated 6/01/11 at 11:20 a.m., signed by the physician, included, but was not limited to: "Plan: Therapy eval (evaluation) re (regarding) footwear options. Prognosis guarded due to morbid obesity/venous stasis and noncompliance history with treatment." An undated, hand written note indicated "Spoke with [named] in therapy will check on options noted by (named) RN 6/1/11 2:30 p.m.<br><br>On 7/12/11 at 11:40 a.m., in interview with Physical Therapist #1, she indicated, she had spoken with the Social Worker and it was not "in their scope of practice." | | | |

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| | The Social Worker was in the room and indicated "she can't get shoes, she can't pay for them and she did not see the order." The Director of Nursing, who was present, indicated "it was not done and fell through the cracks."<br><br>Documentation was lacking in the clinical record of the physician being notified the footwear options had been obtained.<br><br>C. 2. The clinical record for Resident #91 was reviewed on 7/12/11 at 3:10 p.m. A physician re-write for orders signed and dated June 2011 included but was not limited to: "Exelon (to treat dementia) 9.5 mg (milligram)/24 HR (hour) patch apply 1 patch topically every day. Doc (document) site. Remove old patch. started 12/09/2010"<br><br>The Medication Administration Record for May 2011 and June 2011 included but was not limited to: Exelon Patch not given on May 31, June 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 16. The reverse side of the June 2011 form indicated "6/2 | | | |

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| | Exelon 9.5 mg not available, 6/6 Patch not available."<br><br>In interview with the Director of Nursing on 7/12/11 at 12:45 p.m., she could not explain why the medication was not administered as ordered.<br>She indicated if a resident misses 3 days the MD was to be notified.<br>Documentation was lacking in the Nurses's Notes of physician/family notification.<br><br>3.1-5(a)(2) | | | |
| F0160 SS=D | Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.<br>Based on record review and interview, the facility failed to disperse resident funds to the state agency after death for 1 of 1 deceased resident account reviewed in a supplemental sample of 14 residents. (Resident #92)<br><br>Findings include: | F0160 | **The facility will ensure this requirement is met through the following corrective measures.**<br>**1. Resident #91 is deceased.**<br>**2. All residents have the potential to be affected. Based on audit of resident funds no further alleged deficient practice occurred. 3. The resident refunds for Medicaid Residents policy and** | 08/14/2011 |

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| | On 7/14/11 at 8:18 a.m., Resident Trust Accounts were reviewed with the Business Office Manager.<br><br>Resident #92, a Medicaid recipient, expired on 4/21/11. The resident had a balance of $52.00, in the trust, at the time of death. In interview with the Business Office Manager at 8:20 a.m., she indicated the $52.00 was "applied to the nursing home bill."<br><br>In interview with the Bookkeeper, at this time, she indicated she was instructed by the Corporate Office the funds remaining were to be applied to the outstanding nursing home bill.<br><br>On 7/14/11 at 1:10 p.m., Administrator #1 provided the facility's current undated policy for "Resident Refunds for Medicaid Recipients" which included, but was not limited to: "Resident Expired 1. Be sure there are no outstanding balances in A/R (Accounts Receivable). Make sure all charges have been entered such as beauty shop, cable, etc. Send balance inquiry to corporate biller for approval before sending personal funds balance anywhere. If there are any balances in A/R of any pay type then the balance in resident trust is to be deposited towards resident A/R Account...6. If there are no outstanding balances and if there is | | **procedure was reviewed and revised. (See attachment C). Business Office staff was inserviced on this procedure. The administrator or designee will review resident trust fund balances weekly times 4 weeks then monthly thereafter. (See attachment D). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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| | no surviving spouse and there are no outstanding funeral expenses, you must send the remaining resident trust funds and/or credit balances in A/R to the Treasurer, State of Indiana...."<br><br>3.1-6(h) | | | |
| F0250 SS=D | The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>Based on record review and interview the facility failed to ensure medically related social services were provided for 1 of 1 resident reviewed for footwear in a resident sample of 15. (Resident #1)<br><br>Findings include:<br><br>During the initial tour on 7/11/11 between 9:15 a.m. and 10 a.m., resident #1 was observed propelling in a wheelchair. At the time, the resident had ankle length socks to both feet.<br><br>The clinical record for Resident #1 was reviewed on 7/11/11 at 1 p.m. The resident's diagnoses included, but were not limited to venous stasis ulcers and morbid obesity. A physician progress note dated 6/01/11 at 11:20 a.m., signed by the physician, included, but was not limited to: "Plan: Therapy eval | F0250 | **The facility will ensure this requirement is met through the following corrective measures. 1. Resident #1 has received shoes in accordance with her wishes. Physician is aware the resident has footwear. 2. All residents have the potential to be affected. 3. The administrator or designee will review 5 resident charts weekly times 4 weeks then monthly x 2 months, then quarterly thereafter to ensure any social service needs are addressed. (See attachment E). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | 08/14/2011 |

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| | (evaluation) re (regarding) footwear options. Prognosis guarded due to morbid obesity/venous stasis and noncompliance history with treatment." An undated, hand written note indicated "Spoke with [named] in therapy will check on options noted (named) RN (RN #1) 6/1/11 2:30 p.m."<br><br>On 7/12/11 at 11:40 a.m., in interview with Physical Therapist #1, she indicated, she had spoken with the Social Worker and it was not "in their (the therapists) scope of practice." The Social Service Director was in the room and indicated "she can't get shoes, she can't pay for them" and she did not see the order." The Director of Nursing, who was present, indicated "it was not done and fell through the cracks."<br><br>The Social Service Progress Notes reviewed on 7/11/11 at 1 p.m., lacked a notation for 6/1/11 related to obtaining footwear options.<br><br>On 7/14/11 at 8:40 a.m., Administrator #1 provided the signed and dated Job Description for the Social Service Director, which included, but was not limited to "9. Ensure residents have all necessary personal care items either by notifying families or shopping for residents. 10. Communicate with | | | |

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| | government agencies, community resources, etc. (etcetera), regarding resident needs or problems (e.g., Medicaid applications, legal aids, etc.)...12. Respond promptly to notification that a resident has a social service concern warranting intervention...."<br><br>3.1-34(a) | | | |
| F0253 SS=E | The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br>A. Based on observation, record review and interview, the facility failed to ensure furniture, over the bed lights, and ceiling light covers were clean and in good repair during environmental observations. This deficient practice affected 15 of 69 residents in 12 occupied rooms.<br><br>B. Based on observation and interview, the facility failed to ensure a call system was readily available in the small dining/activity room. This deficient practice had the potential to affect 7 of 7 residents observed during lunch and 9 of 9 residents observed during supper in the dining/activity room.<br><br>Findings include:<br><br>A. On 07/12/11 between 9:59 a.m., and | F0253 | **The facility will ensure this requirement is met through the following corrective measures. 1. The end cap on the hand rail was repaired. Room 24 bedframe was cleaned and light cover was repaired Room 17 ceiling light cover was replaced, bed was cleaned, cubicle curtain repaired A room 15 light bulb was replaced and marred areas repaired Room 50, 51 and 49 bed frames were cleaned Room 34 frame was cleaned, chest of drawers was removed, over bed lights cleaned. Cubicle curtain repaired. Room 47 frame and over bed lights were cleaned. Cubicle curtain repaired Room 46 bed frame cleaned. Cubicle curtain repaired. Cubicle curtain track was repaired. Room 44 bed** | 08/14/2011 |

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| | 10:55 a.m., the following was observed:<br><br>1. The end cap on the hand rail was loose on the hallway with social service office and leading towards the secured unit.<br><br>2. Room 24--One bed frame was soiled with heavy dust. The ceiling light cover was loose.<br><br>3. Room 17--Two ceiling lights lacked a cover, one bed was soiled with heavy dust that rolled when swiped with the fingers. The cubicle curtain on one bed failed to enclose the bed when pulled to provide privacy.<br><br>4. Room 15--The light bulb in 1 ceiling light and in above the hand sink flashed on/off. The wall covering was marred behind the bed next to the floor 1 inch in 6 areas.<br><br>5. Room 51-- The frame of one bed was soiled with heavy dust.<br><br>6. Room 50-- The frame of one bed was soiled with heavy dust.<br><br>7. Room 49--The frames of both beds were soiled with heavy dust.<br><br>8. Room 34--The frame of one bed was soiled with heavy dust. A chest with 4 | | **frames and bed light was cleaned Room 43 bed frames was cleaned, caulking was replaced around the base of the toilet on, the orange substance on the floor was cleaned Room 41 bed frames and bed light was cleaned. The closet doors were replaced The ceiling light cover in the hall outside the Dining/Activity room was replaced A call system has been implemented in the small dining room to include call bells and a phone is in the adjacent dining room with posted instructions for use. 2. All residents have the potential to be affected. 3. The cleaning schedule and preventative maintenance schedule have been reviewed. Housekeeping staff have been reinserviced on the cleaning schedule. (See attachment F) The maintenance supervisor has been re-educated on the preventative maintenance schedule. (see attachment Ga).Housekeeping supervisor or designee will complete environmental audits daily during scheduled working days x 4 weeks then weekly x 4 weeks then monthly thereafter. (See attachment G) The administrator of her designee will check the PM log and make facility rounds weekly for two months then monthly** | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | drawers had the finish missing on 3 drawers on the outer corners. Two over the bed lights were soiled with heavy dust. One cubicle curtain was short and failed to enclose the bed and the curtain track was loose from the ceiling.<br><br>9. Room 47--The frame of one bed and two over the bed lights were soiled with heavy dust. The cubicle curtain for bed 2 failed to completely enclose the bed to provide privacy.<br><br>10. Room 46--The frame of one bed was soiled with heavy dust. The cubicle curtain failed to completely enclose the bed for bed 2. A portion of the finish approximately 3 inch by 1 inch on the ceiling by the curtain track was missing.<br><br>11. Room 44--The frames of two beds and one over the bed light were soiled with heavy dust.<br><br>12. Room 43-- The frames of two beds and 2 over the bed lights were soiled with heavy dust. The caulking at the base of the toilet in the bathroom was stained. The flooring by the hand sink was stained with a orange substance approximately 6 inches.<br><br>13. Room 41-- The frames of two beds and two over the bed lights were soiled | | **thereafter to ensure concerns are addressed timely (see attachment G).4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14, 2011.** | |

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|---|---|---|---|---|
| | with heavy dust. The closet door was off the track on the right side.<br><br>14. A ceiling light cover in the hall outside of the Dining/Activity room was cracked.<br><br>On 7/13/11 at 8:59 a.m., the Housekeeping account manager provided the HouseKeeping Project Calendar for July. The weekly schedule was as follows: Monday Bedframes Low Dust, Tuesday High Dust, Wednesday Trash Cans, Thursday Tables & Chairs, Friday window Blinds Ceils (sic). The Housekeeping Deep Clean Calendar for July 2011 provided at this time indicated each room was done on a monthly basis.<br><br>On 7/15/11 at 12:45 p.m., Administrator #1 indicated an audit of the privacy curtains showed the long vs short curtains were placed on the wrong tracks in resident rooms.<br><br>B. During the initial tour on 7/11/11 between 9:15 a.m. and 10:30 a.m., a call light was noted near the entrance to the small dining room with no cord attached. It was again noted during the lunch observation on 7/11/11 between 11:30 a.m. and 12 p.m. with 7 residents present. On 7/12/11 at 5 p.m., 9 residents were in the small dining room. The call light had | | | |

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| | no cord attached.<br><br>On 7/12/11 at 6:30 p.m., Administrators #1 and #2 pressed the button on the call system and no lights nor sounds were heard. In interview, at this time, they were not aware of how long the system had been out of service.<br><br>On 7/15/11 at 11:30 a.m., two bells were sitting on the second shelf from the top of a cabinet in the small dining room out of reach of the 2 (two) residents seated in their wheelchairs.<br><br>3.1-19(f) | | | |
| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br>A. Based on record review, observation and interview, the facility failed to ensure a physician order for footwear was obtained for 1 of 1 resident reviewed for footwear and failed to follow medication orders for 1 of 15 residents reviewed for medications in a sample of 15. (Resident #1, #91)<br><br>B. Based on record review and | F0282 | **The facility will ensure this requirement is met through the following corrective measures: 1. Resident #1 has received shoes of her wishes and the physician is aware. Resident #22 has been assessed by OT, PT, and ST. Resident #91 is deceased. 2. All residents have the potential to be affected Nurse's Notes, MAR's and new physician orders were reviewed for past 30 days to ensure services were provided based on physicians order or assessment, as** | 08/14/2011 |

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|---|---|---|---|---|
| | interview, the facility failed to ensure the resident had been assessed by occupational therapy, physical therapy and speech therapy as ordered by the physician upon admission orders for 1 of 3 residents reviewed for therapy in a sample of 15. (Resident #22)<br><br>Findings include:<br><br>A.1. During the initial tour on 7/11/11 between 9:15 a.m. and 10 a.m., resident #1 was observed propelling in a wheelchair. At the time, the resident had ankle length socks to both feet.<br><br>The clinical record for Resident #1 was reviewed on 7/11/11 at 1 p.m. The resident's diagnoses included, but were not limited to venous stasis ulcers and morbid obesity. A physician progress note dated 6/01/11 at 11:20 a.m., signed by the physician, included, but was not limited to: "Plan: Therapy eval (evaluation) re (regarding) footwear options. Prognosis guarded due to | | **deemed necessary and in accordance with the care plan. 3. The physician notification with acute changes in condition (see attachment A); medication administration (See attachment I); physician's orders (See attachment J) policy and procedures were reviewed and no changes were indicated at this time. Licensed staff were re-educated on the procedures. The DON or her designee will review Nurse's Notes and new physician orders daily on scheduled work days to ensure physicians and family members are notified timely with changes and condition and that adequate follow-up/through is completed when new orders are obtained. (See attachment B) The DON or designee will audit MAR's three times weekly for one month, then twice weekly for one month, then weekly for one month, then monthly thereafter to ensure medications are given as ordered and, if held, proper physician notification is made and noted (see attachment Z).4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be** | |

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| | morbid obesity/venous stasis and noncompliance history with treatment." An undated hand written note indicated "Spoke with [named] in therapy will check on options noted by (named) RN 6/1/11 2:30 p.m."<br><br>On 7/12/11 at 11:40 a.m., in interview with Physical Therapist #1, she indicated, she had spoken with the Social Worker and it was not "in their (the therapists) scope of practice." The Social Worker was in the room and indicated "she can't get shoes, she can't pay for them and she did not see the order. The Director of Nursing, who was present, indicated "it was not done and fell through the cracks."<br><br>A.2. The clinical record for Resident #91 was reviewed on 7/12/11 at 3:10 p.m. The record indicated the resident was admitted 2/10/03. A physician re-write for orders signed and dated June 2011 included but was not limited to: "Exelon (to treat dementia) 9.5 mg | | **completed on or before August 14th, 2011.** | |

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| | (milligram)/24 HR (hour) patch apply 1 patch topically every day. Doc (document) site. Remove old patch. started 12/09/2010."<br><br>The Medication Administration Record for May 2011 and June 2011 included but was not limited to: Exelon Patch not given on May 31, June 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 16. The reverse side of the June 2011 form indicated "6/2 Exelon 9.5 mg not available, 6/6 Patch not available."<br><br>The resident expired on 6/17/11. A Returned Medications Request for Credit form dated 6/18/11 included, but was not limited to: Exelon 9.5 mg/24 HR patch; date filled 5/31; 26 returned.<br><br>In interview with the Director of Nursing on 7/12/11 at 12:45 p.m., she could not explain why the medication was not administered as ordered.<br>B. On 7/13/2011 at 9:05 a.m. record review indicated Resident # | | | |

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| | 22 had diagnoses of, but was not limited to, dementia, diabetes mellitus, schizophrenia, tardive dyskinesia, coronary artery disease, and dysthmia.<br><br>On 7/13/2011 at 9:05 a.m. review of physician orders dated 6/27/2011, indicated physical therapy (P.T.), occupational therapy (O.T.) and speech therapy were to assess Resident # 22. Documentation was lacking P.T., O.T., and speech therapy had assessed the resident.<br><br>On 7/13/2011 at 11:15 a.m. Licensed Practical Nurse (L.P.N.) # 3 indicated O.T., P.T., and speech therapy had not yet assessed resident.<br><br>On 7/13/2011 at 12:40 p.m. in interview with P.T. # 1 and O.T. # 1, they indicated they had not received an order to assess Resident # 22. O.T. # 1 indicated the primary speech therapist # 1 was on vacation, and in her absence speech | | | |

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|---|---|---|---|
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| | therapist # 2 was seeing residents. O.T. # 1 indicated speech therapist # 2 comes three times a week and was not here on this day. O.T. # 1 reviewed online records and documentation was lacking to indicate speech therapy had seen Resident # 22.<br><br>On 7/13/2011 at 1:00 p.m. Registered Nurse (R.N.) # 2 indicated 16 days was too long for a referral not to have been made to O.T., P.T., and speech therapy.<br><br>3.1-35(g)(2) | | | |
| F0333 SS=D | The facility must ensure that residents are free of any significant medication errors.<br>Based on record review and interview, the facility failed to ensure medications were administered as prescribed by the physician. The deficient practice resulted in a significant medication error for 1 of 15 residents reviewed related to medication administration in a sample of 15. (Resident #91)<br><br>Findings include: | F0333 | **The facility will ensure this requirement is met through the following corrective measures:**<br>**1. Resident #91 is deceased.**<br>**2. All residents have the potential to be affected. MAR's were audited for the past 30 days to ensure medications were administered as ordered and, if held, proper physician notification was made and noted.3. The medication administration policy and procedure has been reviewed and no changes were made. (See attachment I). Nursing** | 08/14/2011 |

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| | 1. The clinical record for Resident #91 was reviewed on 7/12/11 at 3:10 p.m. The record indicated the resident was admitted 2/10/03. A physician re-write for orders signed and dated June 2011 included but was not limited to: "Exelon (to treat dementia) 9.5 mg (milligram)/24 HR (hour) patch apply 1 patch topically every day. Doc (document) site. Remove old patch. started 12/09/2010."<br><br>Review of the 2010 Nursing Spectrum Drug Handbook on 7/12/11 at 3:40 p.m., included, but was not limited to: "Closely monitor cognitive status, particularly memory. Report significant decline or improvement...Tell caregiver that memory improvement generally is subtle and that drug works by preventing further memory loss..."<br><br>The Medication Administration Record for May 2011 and June 2011 included but was not limited | | **staff were reeducated on the medication administration policy and procedure. The DON or designee will monitor Medication Administration Records three times weekly for one month, then twice weekly for one month, then weekly for one month, then monthly thereafter (See attachment Z). 4. Findings of these audits will be reviewed during the facility' s quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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| | to: Exelon Patch not given on May 31, June 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, and 16. The reverse side of the June 2011 form indicated "6/2 Exelon 9.5 mg not available, 6/6 Patch not available."<br><br>The resident expired on 6/17/11. A Returned Medications Request for Credit form dated 6/18/11 included, but was not limited to: Exelon 9.5 mg/24 HR patch; date filled 5/31; 26 returned.<br><br>In interview with the Director of Nursing on 7/12/11 at 12:45 p.m., she could not explain why the medication was not administered as ordered.<br>She indicated if a resident misses three days the MD was to be notified. Documentation was lacking in the Nurses's Notes of physician/family notification.<br><br>3.1-25(b)(9)<br>3.1-48(c)(2) | | | |

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| F0364 SS=E | Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br>Based on observation, record review and interview, the facility failed to ensure food was prepared in a manner to preserve nutritive value and flavor, in that recipes were not followed in 1 of 1 observation of preparation of pureed foods. This deficient practice had the potential to affect 16 of 16 residents who received pureed diets.<br><br>Findings include:<br><br>On 07/11/11 at between 10:30 a.m. and 10:47 a.m., the following was observed during preparation of pureed foods.<br><br>1. At 10:30 a.m., cook #1, indicated she was pureeing foods for 16 residents. Using a 6 ounce scoop, she measured 16 portions of the Chicken Casserole into the Robo Coupe (food processor) the scoops lacked being completely full approximately 1/4 inch from the top of the scoop. She added 16 slices of bread and 7 cups of broth and processed the items and then placed in the steamer.<br><br>2. At 10:27 a.m., cook #1, again indicated she was preparing pureed carrots for 16 residents. She indicated she had already | F0364 | **The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed.2. All residents receiving puree diet have the potential to be affected. 3. All cooks were in-serviced on the facility pureed policy. (See attachment L) The dietary manager or her designee will observepuree preparation 5 x per week, alternating between breakfast, lunch and supper for four weeks; then three times per week for 4 weeks, then weekly indefinitely (See attachment M). 4. Findings of these audits will be reviewed during the facility's quality assurance meeting and the plan of action adjusted accordingly.** 5. The above corrective measures will be completed on or before August 14, 2011. | 08/14/2011 |

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| | prepared 8 servings and needed to prepare 8 more servings. Using a 4 ounce ladle (1/2) cup she placed 8 servings in the Robo Coupe added 3 and 2/3 cups of broth and processed. She indicated she added the margarine while cooking the carrots.<br><br>At 11:10 a.m., the dietary manager provided a copy of the recipes for the pureed casserole and carrots which were reviewed at this same time..<br><br>The recipe for the Pureed Casserole read as follows:<br>16 servings<br>Cooked Casserole: 16 cups<br>Bread: 16 slices<br>Broth: 8 cups<br><br>Cook #1, measured the portions of casserole using a 6 ounce measure instead of the 8 ounce measure for a cup. The recipe called for 8 cups of broth and only 7 were added.<br><br>Pureed Vegetables<br>16 servings<br>Cooked Vegetables: 8 cups<br>Broth: 1 -3/8 cups<br>Margarine: 1/2 cup<br><br>To complete the additional 8 servings of pureed carrots cook #1, placed 4 cups of | | | |

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| | cooked carrots in the Robo Coupe, added 3 cups of broth and processed. She failed to add the margarine as the recipe called for and added more than the required broth for 16 servings.<br><br>3.1-21(a)(1) | | | |
| F0365 SS=D | Each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br>Based on record review, interview and observation, the facility failed to ensure 1 of 1 resident at risk for choking/coughing while eating in a sample of 15 residents, received the correct food consistency (pureed) for 1 of 2 meals observed. (Resident #52)<br><br>Finding includes:<br><br>Review of the clinical record for Resident #52 on 7/13/2011 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to, multi-infarct dementia, cataracts, and status post cerebral vascular accident (stroke).<br><br>Review of the July 2011 monthly physician orders indicated the resident was to receive a pureed diet due to being | F0365 | **The facility will ensure this requirement is met through the following corrective measures: 1. Resident #52 was not harmed.2. All residents on a mechanically altered diet have the potential to be affected. 3. The Reading Tray Cards policy and procedures were reviewed with no changes made. (See attachment N). Dietary staff were re-educated on this policy. The dietary manager or her designee will audit pureed diets preparation 5 x week, alternating between breakfast, lunch and supper for 4 weeks; then 3 x per week x 4 weeks, then weekly indefinitely (See attachment M).**<br>**Additionally, the DON or her designee will audit 1 meal service per day for four weeks, then weekly thereafter to ensure diets are served as** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | at risk for coughing/choking.<br><br>During the lunch observation on 7/11/2011 at 12:20 p.m., the resident's family member was overheard to tell CNA #2 that the resident had received regular peaches instead of pureed peaches like she was supposed to have. Observation of the bowl given to the CNA noted the bowl to contain regular peach cubes.<br><br>An interview with the CNA at this time indicated the resident was supposed to have pureed peaches not the regular ones she had received. The family member also indicated that this happens on occasion when he comes in to feed the resident and he had to ask the staff to get her the correct food.<br><br>3.1-21(a)(3) | | **ordered (See attachment O).<br>4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14, 2011.** | |
| F0366<br>SS=E | Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.<br>Based on record review, observation and interviews, the facility failed to ensure residents received substitutes for menued items listed on their dislike list. This deficient practice affected 4 of 15 residents in a sample of 15 residents and 11 of 14 residents in a supplemental sample of 14 residents who were | F0366 | **The facility will ensure this requirement is met through the following corrective measures:<br>1. No residents were harmed. All resident food preferences were updated to reflect current preferences. All alert and oriented residents select what they will be served at lunch** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | reviewed for food likes and dislikes. (Residents #9, 17, 74, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, and 111)<br><br>Findings include:<br><br>During the group meeting on 7/11/2011 at 1:30 p.m., Residents #100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, and 111 indicated their likes and dislike for certain food items were not being followed and would get served the items anyway. The residents indicated that their dislikes were listed on the tray cards dietary follows for each meal but that they received the items anyway.<br><br>During the lunch observation on 7/11/2011 between 12:20 p.m. and 12:45 p.m., the menued main course was "Chicken Casserole" and the following was observed:<br>1. Resident #107 had received the broccoli and chicken casserole although her tray card indicated she did not like broccoli. During an interview with the resident at 12:27 p.m., she indicated she would just pick it out.<br><br>2. Resident #17 had received the broccoli and chicken casserole although his diet card had indicated he did not like | | **and supper. 2. All residents have the potential to be affected. All residents have been interviewed for preferences and will be re-interviewed on a quarterly basis to ensure updates are listed. 3. The Reading tray cards policy and procedure was reviewed with no changes made (See attachment N). All dietary staff members were in-serviced on the above policy. Nursing staff were also educated to ensure that tray cards are reviewed to ensure likes and dislikes are honored prior to delivery. The dietary manager or designee will audit tray card accuracy and food preferences 5 x week, alternating between breakfast, lunch and supper for 4 weeks; then 3xweek for 4 weeks, then weekly indefinitely (See attachment O). The DON or her designee will audit 1 meal service per day during scheduled working hours for four weeks, then weekly indefinitely (See attachment O). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.** 5. The above corrective measures will be completed on or before August 14, 2011. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | broccoli. During an interview with his family member at 12:29 p.m., she indicated the resident did not like broccoli and she would have to just pick it out. She also indicated that this happens a lot and one usually has to tell the staff to get him something else. The family member was then overheard to ask a staff member to get the resident a sandwich as she did not think the resident would have enough to eat after she picked the broccoli out.<br><br>3. Resident #74 had received the broccoli and chicken casserole although his diet card listed broccoli as a dislike. The resident was observed to not eat his meal although he did not ask for anything else.<br><br>4. Resident #111 was observed to have received the main course of chicken and broccoli casserole but was heard to ask for something else. When interviewed about the main course and the reason for asking for another entree, the resident indicated he did not like broccoli and the kitchen knew it.<br><br>5. Resident #104's lunch tray was observed to have carrots on it as the vegetable and the resident was overheard to tell the staff "Well, they can just take that back. I have never eaten carrots." During an interview with him at 12:42 p.m., the resident indicated he had never | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | eaten carrots and staff knew it.<br><br>During an interview with CNA#1 on 7/12/2011 at 12:10 p.m., she indicated dietary was the main one responsible for checking and ensuring the diet cards were followed but that the nursing staff passing the trays were also supposed to. She indicated she had let a few things get by her yesterday and that she did not check the tray cards like she should have.<br><br>During an interview with Resident #9 on 7/12/2011 at 4:00 p.m., she indicated she had a number of food dislikes and that although the kitchen was aware of them, she continued to receive those dislikes anyway.<br><br>On 7/13/2011 at 2:55 p.m., the Business Office Manager presented a copy of Cook/Dietary Aide #1's and Dietary manager's signed job descriptions dated 1/27/2010 (cook) and 9/18/2009 (dietary manager). Review of these job descriptions included, but were not limited to:<br><br>1. "Cook/Dietary Aide:... Essential Responsibilities:...4. Review menus prior to preparation of food and inspect all trays to ensure completion and accuracy of menu and diet preferences..." On 1/29/2010, Cook #1 was checked of as | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | having been oriented to "Inspecting Meal Trays for Accuracy".<br><br>2. "Director of Food Service:...Essential job Functions:...4. Ensure meals are prepared and served in accordance with menu and diet preferences and established portion control procedures."<br><br>During an interview with the Director of Food Service on 7/14/2011 at 1:40 p.m., she indicated the residents have a selective menu and will choose their own items with the help of nursing staff. She indicated that if the residents choose the main course, i.e. broccoli and chicken casserole, then they get the item even if some of the ingredients was on their dislike list. She further indicated that she did not go back and double check with the resident if they circled a disliked item and that it was up to the CNAs to know the likes and dislikes of the residents when helping them with their selective menus.<br><br>Review of the 7/11/2011 menu for lunch listed "Chicken Casserole" as the main choice although the recipe presented by the Director of Nursing on 7/13/2011 at 1:55 p.m., indicated it really was "Broccoli and Chicken Casserole.<br><br>During an interview with CNAs #3 and #4 on 7/14/2011 at 1:45 p.m., they indicated | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | that most of the residents could tell them which item they would like on their selective menu and that they try to remember the dislikes of the residents in order to add something different but was not always easy to do. They indicated the residents on pureed diets just get whatever was being pureed with no choice to pick another item if something was a dislike to them. CNA #3 further indicated that because the residents on the Alzheimer wing were unable to make a choice in their selective menus most of the time, it was a trial and error process with the likes and dislikes.<br><br>3.1-21(a)(4) | | | |
| F0371 SS=F | The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | | | |
| | Based on observation, record review and interview, the facility failed to ensure equipment was clean and food was prepared under sanitary conditions on 2 of 3 dietary observations. This deficient practice had the potential to affect 68 of 69 health center residents who received meals from the kitchen.<br><br>Findings include: | F0371 | **The facility will ensure this requirement is met through the following corrective measures:<br>1. No residents were harmed. All areas of concern have been corrected. The milk cooler has a thermometer. Dietary staff are recording temperatures 2 x a day. A cover was installed over the light in the freezer. The fan was cleaned. All ceiling vents were cleaned.2. All residents** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | On 07/11/11, between the hours of 9:22 a.m. and 9:49 a.m., the following was observed:<br><br>1. The milk cooler lacked a thermometer and documentation the temperatures were taken this a.m., was lacking.<br><br>2. The light in the freezer lacked a cover. The temperature registered greater than zero degrees on 3 thermometers. The pizza crust and 2 containers of ice cream were not frozen solid, but had ice crystals. Moisture was dripping from the ceiling. In interview with the dietary manager at 9:00 a.m. she indicated the concern was reported to maintenance at 9:15 a.m., in the morning meeting.<br><br>3. Four large deep and three small steam table pans stored as clean were soiled with food on the inner surfaces.<br><br>4. A large fan was soiled with dust on the fan blades and guard. The dietary manager indicated the fan is cleaned every 2 weeks.<br><br>5. Two ceiling vents located over the clean side of the dish machine were soiled with heavy dust.<br><br>6. At 11:23 a.m., on 07/11/11, the freezer | | **have the potential to be affected. See below for corrective measures.3. The Registered Dietician Consultant reviewed ware washing, pot and pan sanitation, recording of equipment temperatures and kitchen sanitation with all dietary employees. The cleaning schedule was revised (see attachment Qa) and a new procedure for responding to cooling equipment failure was written and implemented (see attachment P). The Dietary Manager or her designee will complete sanitation observations and equipment audits daily Monday thru Friday for 4 weeks, then weekly indefinitely (See attachment Q). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.** 5. The above corrective measures will be completed on or before August 14, 2011. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | temperature measured 20 degrees Fahrenheit. In interview with the dietary manager, at this time, she indicated maintenance checked the compressor and turned it back on at 9:45 a.m. She further indicated staff normally take refrigerator and freezer temperatures, when they arrive for work at 6:00 a.m. The freezer temp was documented as minus zero degrees on 07/11/11.<br><br>7. At 12:40 p.m. the freezer temperature was again measured. There were three thermometers located on shelving in the freezer and temperatures measured 20 degrees F. on two and 24 degrees F on one. The temperature for package of cooked pork measured 28 degrees. The dietary manager disposed of the pork and indicated a refrigeration company was contacted.<br><br>A copy of the repair invoice was provided on 07/13/11 and indicated "cleaned condenser coil and adjusted the charge."<br><br>3.1-21(i)(3) | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| F0406 SS=D | If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.<br>Based on record review and interviews, the facility failed to ensure therapy followed up on referrals from nursing to screen a resident after an episode of choking while eating and for wheelchair positioning and/or a new wheelchair due to a decline in condition with increased leaning backwards. This deficient practice affected 1 of 2 residents reviewed for therapy in a sample of 15 residents. (Resident #52)<br><br>Finding includes:<br><br>Review of the clinical record for Resident #52 on 7/13/2011 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to, multi-infarct dementia, cataracts, and status post cerebral vascular accident (stroke).<br><br>On 3/29/2011, nursing made a request for a "Therapy Screen" due to a decline or | F0406 | **The facility will ensure this requirement is met through the following corrective measures: 1. Resident #52 was screened by the speech therapist. 2. All residents have the potential to be affected 3. Facility therapy department has been educated on the facility screen/evaluation and documentation of services policy. (See attachment R). The Administrator or her designee will review requested therapy screens daily, on scheduled work days, during morning meeting until the screen has been completed to ensure screens are completed timely. This will continue indefinitely (See attachment S). 4. Findings of these audits will be reviewed during the facility' s quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | change in physical status and a decrease in ability to sit upright. On 4/8/2011, therapy documented "pt [patient] to be seen by [name of representative from outside mobility company] for custom w/c [wheel chair]. OT [occupational therapy] had attempted multiple w/c in facility [with] limited success. No evals warranted @ [at] this time. Will reass [reassess] following new w/c interventions. [name of company therapist] to assess for custom tilt-in space chair."<br><br>Documentation of this outside mobility company's assessment of the resident for a new wheel chair was lacking until a fax was presented by the corporate nurse on 7/13/2011 at 3:15 p.m. dated 4/14/2011. An interview with COTA #2 [certified occupational therapist assistant] on 7/13/2011 at 11:15 a.m., indicated the outside mobility company came in every week but did not leave any kind of notes with the therapists as to what recommendations were made. She indicated all that was left was a list of who the company was seeing.<br><br>During an interview with COTA #1 on 7/14/2011 at 9:15 a.m., she indicated the resident was initially denied for the new wheelchair but the mobility company was supposed to be re-applying. | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | In a second interview with COTA #2 at 9:18 a.m., she indicated the resident was denied for the wheelchair and it was being re-applied. She indicated that although a denial letter was received by the facility therapy group, they did not keep them as there was no reason to.<br><br>During an interview with the corporate therapist on 7/14/2011 at 2:05 p.m., she indicated the Medicaid system was going through an update and additional information was being obtained to re-apply for the resident's wheel chair as it had been denied originally. She indicated the information was originally sent in April but was denied due to the codes not being accepted and that another application was sent on May 20th to modify a code. She further indicated they were now waiting for Medicaid to reply and agreed that although the specialist from [name of therapy group] was in the facility every week, she had not added the resident to the roster of residents currently being seen until yesterday - 7/13/2011.<br><br>During review of the nursing notes between 3/1/2011 and 7/13/2011, the following entry was noted:<br>- "5/5/11 - 11 p [p.m.]: when feeding res [resident] supper this evening, res. noted to get choked up on liquids & food. Res noted to lean head back & when | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | repositioned repeated this..."<br><br>During an interview with the Director of Nursing [DoN] on 7/13/2011 at 2:00 p.m., she indicated that the resident has a tendency to cough and some staff will chart it as choking.<br><br>On 5/5/2011 after the choking incident, nursing made a referral for "Request for Therapy Screen" due to a decrease in ability to sit up right and an increase in choking/coughing. On 5/27/11, nursing made another referral for "Request for Therapy Screen" due to decline or change in physical status and decrease in ability to sit up right. Documentation was lacking by therapy of the screenings have been completed.<br><br>During an interview with COTA #2 on 7/13/2011 at 11:15 a.m., she indicated she would have to look through the files to see if the 5/5 and 5/27/2011 screens had been completed.<br><br>During an interview with COTA #1 on 7/14/2011 at 9:15 a.m., she indicated the therapy staff were still looking for the screens for the 5/5 and 5/27/2011 referrals. She indicated that speech therapy would have been the one to do the screen due to it involving the resident choking while eating and that as far as she | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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| | knew, the screens had not been done.<br><br>During an interview with the corporate therapist on 7/14/2011 at 2:05 p.m., she indicated the resident had not been seen by the Speech Therapist in reference to the 5/5 and 5/27/2011 referrals by nursing to evaluate the resident's positioning in the wheel chair and the episode of choking.<br><br>3.1-23(a)(1) | | | |
| F0425 SS=D | The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.<br>Based on record review, observation and interview, the facility failed to ensure medication was properly disposed of and/or returned to pharmacy for 1 of 1 resident reviewed for disposition of | F0425 | **The facility will ensure this requirement is met through the following corrective measures:<br>1. Resident #92 is deceased and medications were disposed of.2. All residents have the potential to be** | 08/14/2011 |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | medications in a supplemental sample of 14. (Resident #92)<br><br>Findings include:<br><br>On 7/11/2011 at 12:20 p.m., medications for Resident # 92 were in a bin in the medication room to be returned to pharmacy. These included Depakote liquid dated 5/9/2011 approximately 11 oz., Glucagen 1mg injection for hypoglycemia dated 4/21/2011 and 2 bottles of Reglan dated 5/9/2011 approximately 20 oz.<br><br>On 7/11/2011 at 12:00 p.m., in interview with Licensed Practical Nurse (LPN) # 2, she indicated medications were to be returned to pharmacy within 7 days from being discontinued.<br><br>On 7/11/2011 at 12:25 p.m., in interview with LPN # 1, she indicated over the weekend she was cleaning out a medication cart and found the medication, when checking for discontinued and expired medication. LPN # 1 indicated Resident # 92 had expired "sometime end of May."<br><br>On 7/11/2011 at 1:00 p.m.,. record review of facility's discharges over 90 days included; but was not limited to, Resident # 92 RHC'D (respirations have ceased) | | **affected. An audit of all medication carts and medication rooms was conducted to ensure all medications needing dispositon have been in a timely manner. 3. Licensed nursing staff have been re-inserviced on the medication destruction policy. ( See Attachment T). The DON or her designee will audit to ensure medications are returned or destroyed in accordance with facility policy and documented appropriately weekly x 8 weeks, then monthly x2 months and quarterly thereafter. (See Attachment U) 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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|---|---|---|---|---|
| | May 27, 2011.<br><br>On 7/12/2011 at 9:25 a.m., the Director Of Nursing (DON) provided the Policy and Procedure for the DESTRUCTION OF MEDICATIONS which indicated, but was not limited to, "Any medication for which there is no active order shall be destroyed at the nursing facility as soon as possible, but no later than within seven (7) days of becoming active".<br>Procedure-A, 1. indicates, "as soon as a medication becomes inactive, the unit charge nurse or designee should remove all supplies of the drug from stock, count the remaining doses, fill out the Drug Disposal Log (sample on page 90), and destroy the medication. 4. Oral solid dosage forms should be flushed down a toilet. Oral liquid may be flushed or rinsed down a sink. Injectable medications must be withdrawn from the ampule or vial and rinsed down a sink".<br><br>3.1-25(a) | | | |
| F0428 SS=D | The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br>Based on record review and interview, the | F0428 | **The facility will ensure this requirement is met through the** | 08/14/2011 |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

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|---|---|---|---|---|
| | facility failed to ensure consultant pharmacy recommendations for discontinuing duplicate and/or unnecessary stomach medications and unused PRN [as needed] medications were acted upon for 1 of 15 residents reviewed for pharmacy recommendations in a sample of 15 residents. (Resident #58)<br><br>Finding includes:<br><br>Review of the clinical record for Resident #58 on 7/12/2011 at 11:00 a.m., indicated the resident had diagnoses which included, but were not limited to, hiatal hernia and diverticular disease.<br><br>On 7/12/2011 at 2:35 p.m., the DoN [Director of Nursing] presented the following consultant pharmacist recommendations:<br><br>1. On 3/11/2011: "(Resident) has orders for routine Omeprazole (20 mg [milligrams] daily for GERD [gastroesophageal reflux disease] - ordered 7/1/10) AND Pantoprazole (40 mg daily for GERD - ordered 12/15/10). Will you please D/C [discontinue] one of these medications, as they are both in the same class (proton pump inhibitors) and use of both medications is a duplication in therapy. | | **following corrective measures: 1. Resident #58 Omeprozole, Alamag, PRN Tylenol, and Guaifenesin was discontinued in accordance with pharmacy recommendations. 2. All residents have the potential to be affected. An audit of the last 90 days of pharmacy recommendations was completed to ensure all had been addressed with the physician as indicated.3. The DON was inserviced on timely pharmacy recommendation follow-up. The Administrator or her designee will review pharmacy recommendation reports monthly upon arrival to the facility, following up daily until the recommendation is addressed monthly for three months then quarterly thereafter (See attachment V). 4. Findings of these audits will be reviewed during the facility' s quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

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|---|---|---|---|---|
| | 2. On 5/9/2011: "(Resident) has the following routine orders for gas relief: 1. Alamag Plus liquid - take 5 ml [milliliters] PO TID [by mouth three times daily].<br>2. Simethicone 80 mg TID. Because both of these medications contain simethicone, will you consider D/Cing her Alamag liquid (aluminum and magnesium hydroxide do not provide gas relief and may be unnecessary in this case) and keeping only her simethicone tablets?<br><br>3. On 6/13/2011: "(Resident) has the following PRN medication orders: 1. Acetaminophen [APAP] 325 mg tabs - 2 tabs (650 mg) Q [every] 4 PRN pain...also receives routine APAP 650 mg Q AM. 2. Guaifenesin 100 mg/5 ml syrup - 10 ml (200 mg) PO q 4h (hour) PRN cough/URI [upper respiratory infection] (1/25/11). If these medications have not been used in at least 60 days, will you please consider D/Cing these orders?<br><br>During an interview with the DoN at the time she presented the recommendations, she indicated these pharmacy recommendations had not been acted upon yet as she had fallen behind in some. She further indicated the facility had changed the system with the pharmacist for better tracking. | | | |

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| | 3.1-25(j) | | | |
| F0514 SS=D | The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br>Based on record review and interview, the facility failed to document a complete and accurate assessment of a resident after she had experienced an episode of choking while eating. This deficient practice affected 1 of 15 residents reviewed for complete and accurate records in a sample of 15 residents. (Resident #52)<br><br>Finding includes:<br><br>Review of the clinical record for Resident #52 on 7/13/2011 at 9:50 a.m., indicated the resident had diagnoses which included, but were not limited to, multi-infarct dementia, cataracts, and status post cerebral vascular accident (stroke).<br><br>During review of the nursing notes | F0514 | **The facility will ensure this requirement is met through the following: 1. Resident #52 was assessed upon notification of the incident and suffered no negative outcome.2. All residents have the potential to be affected. See below for corrective measures. 3. Clinical documentation policy and procedure policy was reviewed and no changes made (see attachment W). Licensed staff were re-educated on the policy and procedure. The DON or her designee will review Nurse's Notes daily during scheduled working days to ensure appropriate, thorough and timely assessment is completed and documented in the nurses notes. (See attachment B). 4.** | 08/14/2011 |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| | between 3/1/2011 and 7/13/2011, the following entry was noted:<br>- "5/5/11 - 11 p [p.m.]: when feeding res [resident] supper this evening, res. noted to get choked up on liquids & food. Res noted to lean head back & when repositioned repeated this..."<br>Documentation was lacking by nursing of the resident having been assessed right after the incident for possible need for treatment. The 5/5/2011 nursing note was completed over 5 hours after the incident occurred as the posted meal time for the dining room where the resident ate was 5:40 p.m.<br><br>During an interview with the Director of Nursing [DoN] on 7/13/2011 at 2:00 p.m., she indicated that the resident has a tendency to cough and some staff will chart it as choking.<br>She did indicate that staff should have been more specific in their documentation of the incident.<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | **Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |
| F9999 | STATE RULE FINDINGS<br><br>3.1-14 PERSONNEL | F9999 | **The facility will ensure this requirement is met through the following: 1. LPN #1's second step PPD was completed timely in accordance with state** | 08/14/2011 |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

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| | A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test , using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department- approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. | | **regulation and facility policy. 2. All residents have the potential to be affected. A complete audit of employee files was completed to ensure all emplopyees are in compliance. 3. The business office personnel and staff development coordinator were reeducated on the employee health requirements policy. The administrator or her designee will audit new employee files to ensure health requirements are met weekly x2 weeks then monthly x 2 month and quarterly thereafter. (See attachment X) 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |

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|---|---|
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|---|---|---|---|---|
| R0000 | This State Rule was not met as evidenced by:<br><br>Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis at the time of employment or within one month prior to employment. This deficient practice affected 1 of 7 employee files reviewed. (LPN #1)<br><br>Findings include:<br><br>During the review of the employee files on 07/13/11 between 1 p.m. and . 2 p.m., the following was identified:<br><br>LPN (Licensed Practical Nurse) #1 with a start date of 6/15/11, lacked documentation of a second step screening for tuberculosis. The first tuberculin skin test was administered on 6/13/11 and read negative on 6/15/11.<br><br>In interview with the Business Office Manager, on 7/13/11 at 2 p.m., she indicated the second step had not been administered.<br><br>3.1-14(t)<br>3.1-14(t)(1) | | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | The following state residential findings are cited in accordance with 410 IAC 16.2-5. | R0000 | **Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the state of deficiencies. This Plan of Correction is prepared and submitted because of requires of State or Federal law. Please accept this plan of correction as our credible allegation of compliance.** | |
| R0270 | (c) The facility must meet:<br>(1) daily dietary requirements and requests, with consideration of food allergies;<br>(2) reasonable religious, ethnic, and personal preferences; and<br>(3) the temporary need for meals delivered to the resident ' s room.<br>Based on record review, observation and interviews, the facility failed to ensure residents received substitutes for menued items listed on their dislike list. This deficient practice affected 3 of 8 residential residents in a sample of 8 residential residents who were reviewed for food likes and dislikes. (Residents #112, 113, and 114)<br><br>Findings include:<br><br>During the lunch observation on 7/11/2011 at 12:15 p.m., Resident #114 was observed to have received cauliflower instead of the carrots as his vegetable because he did not like carrots. Review of | R0270 | The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. All resident food preferences were updated to reflect current preferences. All alert and oriented residents select what they will be served at lunch and supper. **2. All residents have the potential to be affected. All residents have been interviewed for preferences and will be re-interviewed on a quarterly basis to ensure updates are listed. 3. The Reading tray cards policy and procedure was reviewed with no changes made (See attachment N). All dietary staff members were in-serviced on the above** | 08/14/2011 |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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| | his diet card on his tray indicated not only did he not like carrots, he also did not like cauliflower. When interviewed at this time, he indicated this happens a bunch and that if he didn't like it, he just would not eat it.<br><br>During a second interview with Resident #114 on 7/13/2011 at 10:00 a.m., he indicated dietary continually sends his peas and carrots even though he does not like them and his tray card likes them under his dislikes.<br><br>During the group meeting on 7/11/2011 at 1:30 p.m., Residents' #112 and 113 indicated their likes and dislikes were not being honored and that they would frequently receive food items listed as a dislike.<br><br>During an interview with CNA#1 on 7/12/2011 at 12:10 p.m., she indicated dietary was the main one responsible for checking and ensuring the diet cards were followed but that the nursing staff passing the trays were also supposed to. She indicated she had let a few things get by her yesterday and that she did not check the tray cards like she should have.<br><br>On 7/13/2011 at 2:55 p.m., the Business Office Manager presented a copy of Cook/Dietary Aide #1's and Dietary | | **policy. Nursing staff were also educated to ensure that tray cards are reviewed to ensure likes and dislikes are honored prior to delivery. The dietary manager or designee will audit tray card accuracy and food preferences 5 x week, alternating between breakfast, lunch and supper for 4 weeks; then 3xweek for 4 weeks, then weekly indefinitely (See attachment O). The DON or her designee will audit 1 meal service per day during scheduled working hours for four weeks, then weekly indefinitely (See attachment O). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly.** 5. The above corrective measures will be completed on or before August 14, 2011. | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| | manager's signed job descriptions dated 1/27/2010 (cook) and 9/18/2009 (dietary manager). Review of these job descriptions included, but were not limited to:<br><br>1. "Cook/Dietary Aide:... Essential Responsibilities:...4. Review menus prior to preparation of food and inspect all trays to ensure completion and accuracy of menu and diet preferences..." On 1/29/2010, Cook #1 was checked of as having been oriented to "Inspecting Meal Trays for Accuracy".<br><br>2. "Director of Food Service:...Essential job Functions:...4. Ensure meals are prepared and served in accordance with menu and diet preferences and established portion control procedures."<br><br>During an interview with the Director of Food Service on 7/14/2011 at 1:40 p.m., she indicated the residents have a selective menu and will choose their own items with the help of nursing staff. She indicated that if the residents choose the main course, i.e. broccoli and chicken casserole, then they get the item even if some of the ingredients was on their dislike list. She further indicated that she did not go back and double check with the resident if they circled a disliked item and that it was up to the CNAs to know the | | | |

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|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| | likes and dislikes of the residents when helping them with their selective menus.<br><br>Review of the 7/11/2011 menu for lunch listed "Chicken Casserole" as the main choice although the recipe presented by the Director of Nursing on 7/13/2011 at 1:55 p.m., indicated it really was "Broccoli and Chicken Casserole. | | | |
| R0349 | (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized.<br>Based on record review and interview, the facility failed to document complete eye doctor recommendations for 1 of 1 resident reviewed with recommendations in a sample of 7. (Resident #77)<br><br>Findings include:<br><br>The clinical record for Resident #77 was reviewed on 7/13/11 at 9:10 a.m. The resident was admitted to the residential unit on 7/1/11. A Report of Consultation dated 7/11/11 included, but was not limited to: Recommendations Follow up in 6 months; 1. AREDS vitamin daily; | R0349 | **The facility will ensure this requirement is met through the following corrective measures: 1. Resident #77's recommendations were addressed. 2. All residents have the potential to be affected. MD progress notes and consult notes were reviewed for all residents for the past 60 days to ensure recommendations have been addressed. 3. Licensed staff were re-educated on the need to review all progress notes and consult notes to ensure that recommendations are addressed timely. The DONor her designee will** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155208 | A. BUILDING 00<br>B. WING | 07/15/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HANOVER NURSING CENTER | 410 W LAGRANGE ROAD<br>HANOVER, IN47243 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2. Tears ou (both eyes) 4 - 6 x/day (times/day).<br><br>Review of the July Medication Administration Record lacked the vitamin and tears orders. In interview with LPN#2, she indicated the orders had not been completed. At 10 a.m., LPN #2 provided a Comprehensive Physician's Order Sheet for "Eye Caps (AREDS Vitamin) i (one) po (by mouth) daily. Artificial tears i drop both eyes QID (4 times a day)...." | | **review progress notes and consult notes weekly for 4 weeks, then monthly indefinitely to ensure recommendations are addressed timely (See attachment K). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |
| R0355 | (h) Current clinical records shall be completed promptly, and those of discharged residents shall be completed within seventy (70) days of the discharge date.<br>Based on record review and interview the facility failed to ensure the clinical records were completed promptly after a resident's discharge for 2 of 2 closed records reviewed in a sample of 7. (Resident #80, #81)<br><br>Findings include:<br><br>1. The clinical record for Resident #80 was reviewed on 7/13/11 at 11:20 a.m. The resident was discharged from the assisted living wing to the long term Wing 4 on 1/5/11. Documentation was lacking of a physician order and Nurse's Notes related to the discharge. | R0355 | **The facility will ensure this requirement is met through the following corrective measures: 1. Resident #80 continues to reside on the health care unit. 2. All residents have the potential to be affected. 3. Clinical documentation policy and procedure policy was reviewed and no changes made (see attachment W). Licensed staff were re-educated on the requirements related to a discharge documentation/transfer of level of care documentation. The DON or her designee will review discharged/transferred records to ensure phsycian** | 08/14/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| | 2. The clinical record for Resident #81 was reviewed on 7/13/11 at 11:20 a.m. The resident was discharged from the assisted living wing to the long term care Wing 4 on 1/5/11. Documentation was lacking of a physician order and Nurse's Notes related to the discharge.<br><br>In interview with the Director of Nursing on 7/13/11 at 2 p.m., she indicated no discharge summaries were done on either resident.<br><br>In interview with Administrator #1 on 7/13/11 at 2 p.m., she indicated she was told by the Provider Representative, [name] from the Indiana State Department of Health indicated if they were under one (1) license the chart could follow the resident back and forth and not have to discharge the resident and reopen a clean chart. | | **orders for the discharge/transfer are obtained and documentation regarding the reason for transfer or discharge is documented in the clinical record prior to discharge/transfer weekly x 2 weeks, then monthly x2 months, then quarterly indefinitely (See attachment Y). 4. Findings of these audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of action adjusted accordingly. 5. The above corrective measures will be completed on or before August 14th, 2011.** | |